Blood Is Thicker than Water: Policing Donor Insemination and the Reproduction of Whiteness

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On the most general level, this essay addresses the ways race is deployed in biomedical solutions to infertility. Szkupinski Quiroga begins with general assertions about fertility technology. She then explores how fertility technology reinforces biological links between parents and children and argues that most options reflect and privilege white kinship patterns and fears about race mixing. She illustrates these observations with interviews she has collected.

In 2004, Laura Howard, a forty-year-old nurse, was artificially inseminated at a local fertility clinic.[1] As she was leaving the clinic her doctor suddenly ran out to the lobby and called her back saying: "A horrible mistake has occurred. Come to my office. We need to talk." Ms. Howard had been inseminated with the "wrong" sperm. According to her, the doctor was panicky and encouraged her to get an abortion. That weekend, her doctor called her repeatedly with suggestions on how to terminate her pregnancy. She rejected his counsel, saying, "For me, it's still my child" (Christoffersen 2004). Ms. Howard is African American and the sperm mistakenly used for the insemination was from a white man. Media accounts at the time referred to this case as a "dream . . . turned into a nightmare," "unthinkable," "a fertility screw-up," and a "fiasco." Similar sensationalism occurred fourteen years earlier when a white woman mistakenly received sperm from a black donor. Her insemination was reported as "a tragedy and her life a nightmare" (*New York Times,* March 9, 1990). The degree of media outcry in response to these cases indicates that assumptions about the desirability of racial purity underlie the use of assisted reproductive

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technology (ART). ARTs include intrauterine insemination (IUI) with partner or donor sperm, in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), and surrogacy.[2] These technologies aim to create a baby with a genetic tie to one or both parents. As the U.S. infertility industry is fond of saying, their aim is to "create families." What remains unspoken is the desire to create a certain type of family, one that closely matches, and thus reproduces, the heteropatriarchal model of a white nuclear family.

In this essay, I argue that ARTs's privileging of genetic relatedness is currently deployed in ways that support a white heteropatriarchal model of family in which race and whiteness are reified as inheritable. I begin by outlining the origins of this model in an American kinship system shaped by ideologies of genetic essentialism and racial purity, and then consider aspects of the infertility industry that bolster this particular kinship model. Finally, I analyze narrative accounts of women of color seeking access to donor gametes as a way to illustrate the ways biomedical practitioners maintain patriarchal boundaries of whiteness in their dealings with nonwhite patients.

While feminists have been critical of how ARTs have been deployed in the service of heteropatriarchal notions of family and parenting, detailed considerations of the role of race are less prevalent.[3] With notable exceptions, women of color make brief appearances in the scholarship on ARTs, and then only in discussions of stratified access, questions of distributive justice, or accounts of which groups are most vulnerable to reproductive control. As a Latina feminist, I am encouraged by work that places race at the center of analysis alongside gender, and presents women of color not as victims, but as complex beings with agency. I understand race as a mutable social construction that has been used historically to classify and stratify people based on clusters of physical characteristics. Race is defined by and against whiteness, an unmarked, invisible, and unexamined category that strategically has "a touchstone quality of the normal, against which members of marked categories are defined," so that all members of marked categories possess race in ways that whites do not (Chambers 1997, 189). If whiteness marks what is normal, then anything outside whiteness is marked as deviant or inferior. In considering how race operates in the context of infertility practices, I am attentive to Dorothy Roberts's observation that keeping whiteness pure and unmarked has been the aim of American law and social convention relating to genetics, racial classifications, and reproduction (1997, 267). Understanding whiteness and its power is important to understanding how race is implicated in the use of ARTs as a cultural practice that promotes race-based hierarchies.

Race and the American Kinship Model

Before the advent of ARTs, infertility was understood as a social problem in need of a social solution. Consistent with the privileging of kinship based on blood ties, society saw adoption as the next best choice. As infertility problems became medicalized, the solutions focused on producing a baby with the genetic contributions of a heterosexual couple. ARTs developed in ways that adhered to the contours of the American kinship model. It is important that the bonds determining relatedness in a technologically mediated family be blood ties, or as they are now understood, genetic ties, because the American kinship cultural value is "blood is thicker than water" (Schneider 1984, 84). For Americans, regardless of class or racial background, kinship is rooted in biology via blood and genetics.[4]

The American kinship system is based on the premise that if you have shared "blood," then you are kin (family), and you have kinship obligations. The two distinct, mutually dependent features of the American kinship system are shared biogenetic substance (blood) and diffuse enduring solidarity (love). Together, they comprise an integrated set of symbols that derive from the master symbol of heterosexual intercourse, which is formulated as both a biological entity and a natural act in American culture that explicitly links heterosexuality to reproduction and family (Schneider 1980, 37–38). Biological children of heterosexual couples become symbols of the couple's unity. A child is understood as being composed symbolically of equal contributions of "blood" from both parents, combining to produce a new person who has similar physical and mental attributes. Any variation from this standard, for example, a lesbian couple or single woman raising a child is not seen as a "real" family. ARTs reinscribe this hereditary view of kinship, and perpetuate notions of race being heritable.

Heredity is usually understood simply as the transmission of characteristics and traits from parent to offspring, where the difference between physical expression of genes (phenotype) and the actual inherited genes of the parents (genotype) is obscured. Theories of heritability of the late nineteenth century posited that blood carried traits from one generation to another. The metaphor of blood was, and still is, code for race, with connotations regarding the "sanctity of blood, mixing blood, white blood, black blood, and pure versus tainted blood" (Agigian 2004, 28). Popular aphorisms such as "blood will tell" because "like begets like" reflect the belief that what one inherits from one's parents is more significant and essential than one's social environment. Hereditarianism is a bias common in highly stratified societies and has racial dimensions (Marks 2000). In the United States, the racial hierarchy relies on the idea that intrinsic to whiteness are so-called superior traits that are linked to success. Implicit in this reasoning is that whiteness itself is heritable. However, the flaw

in this argument is that both whiteness and race are social constructions and therefore *not* heritable.

Yet individuals are routinely categorized into races on the basis of certain arbitrary yet heritable traits such as eye shape, hair texture, stature, and skin color. These traits chosen to signify race are highly subjective and distributed across all so-called racial groups, though with differing frequencies. Contemporary anthropologists point out that it would be more accurate to speak about populations—groups of people who have a high frequency of a particular genetic trait—than races (Smedley 1993; American Anthropological Association Working Group 1998). As there is not one gene, heritable cluster of traits, or characteristic that defines racial membership, race is not heritable. Yet the folk idea that race is reducible to biological features remains prevalent.

Twenty-first-century hereditarianism substitutes the idea of blood for genes: now, genes rather than blood will tell. With genetic advances, the vocabulary for grounding difference has been updated and "'blood' is displaced by DNA as the essential marker of shared identity and attribute" (Simpson 2000, 3). Genes determine what you will become: your moral character, intellect, and other traits linked to success and failure are assumed to be inherited. When traits are racialized we assume they refer to corresponding genes. In this update of nineteenth-century theories of racial inheritance, genes have replaced blood but underlying assumptions of racial purity remain. The way kinship is understood in relation to heterosexual intercourse, blood and genes, and heritability is the foundation for the white heteropatriarchal model of family with its embedded ideas of racial purity.

The White Heteropatriarchal Model of Family

The white kinship system emphasizes genetic relationships with the implicit aim of maintaining cultural whiteness, and biomedical technologies for infertility are one means of perpetuating these racialized kinship systems. Because of the nature of the American racial hierarchy, breeding white children and keeping white identity pure and free from nonwhite influences is vital for the preservation of the white family. Physical markers evidence the purity of whiteness. Parents and children in a family must have a phenotypic resemblance (similar physical features) so all family members must be of the same race. In contrast, in families marked as nonwhite or "mixed," it is not unexpected for children not to resemble their parents with regard to skin tone, hair texture, or other markers of race. While biogenetic ties are important to establishing kinship in these families, they are not necessarily essential to determining racial identity.

In the American kinship system, a relationship is crucial to ideas of continuity and reproduction. Reproduction, the replication of the self and the symbolic representation of a bond, "cannot occur in the absence of a certain kind of

knowledge—that is, knowledge about the identity of others" (Strathern 1995, 354). Identity means knowing what characteristics you have and from where you got them. When the characteristics in question are those used to designate one as white, the importance of being able to trace white lineage surfaces. The white kinship model operates as a breeding schema to ensure that whites only reproduce with other whites (Zack 1993, 33). Knowledge of identity also signifies knowledge of the validity of one's claim to whiteness, presumably based on genetics and lineage.

Under the white heteropatriarchal model, women are responsible for maintaining the purity of their bloodline and teaching white culture to their children. The importance of keeping whiteness pure reflects the conviction that mixing "blood" with those who are not white could sully or taint whiteness. Since white women can produce white children only with white men, it is their gender responsibility to safeguard the purity of the white race by adhering to strict standards of sexual behavior, another part of the white kinship model. White couples are encouraged to reproduce, thus materially and culturally perpetuating the white race.

Cultural beliefs about race, purity, and heredity that shape the white heteropatriarchal kinship model are driving forces behind the popularity of ARTs. The medical definition of infertility and corresponding recommended treatments reinforce the importance of privileging genetic ties. Using biomedical interventions to preserve genetic continuity is the favored course of treatment for infertility. In this way, ARTs can be easily understood as cultural practices that support white-centric race-based social hierarchies. The ways ARTs are organized and deployed further supports the white heteropatriarchal model of family, which implicitly guides the actions of biomedical practitioners. As the opening story of this essay suggests, adherence to this model by biomedical practitioners has a differential impact on women of color.

ARTs and the Reproduction of Whiteness

At first glance, ARTs can be classified as either low tech (for example, artificial insemination) or high tech (for example, IVF and its variants), but this binary does not accurately capture the process. For example, feminists once lauded artificial insemination as so low tech that a woman could take control of her own reproduction by inseminating at home using an eyedropper or turkey baster, eliminating any reliance on biomedicine (Klein 1984). By the 1990s, this practice was superseded by commercial sperm banks, which relied on technological treatments and tests unavailable to the home inseminator. Sperm banks are good illustrations of the way ARTs are organized to deliver sperm in ways that valorize technology and expertise—two factors that increase costs and limit access. While sperm banks cannot guarantee fertility, they can offer advanced

medical technology, including access to biomedical experts and technosemen.[5] By using these methods, gamete consumers mistakenly believe they are receiving more advanced reproductive interventions and thus are more likely to have positive results (Everson 2003).

Kathyrn Pauly Morgan's writings about women's choices about ARTs are useful to my own consideration of ARTs and whiteness. According to Morgan,

> Since human choices in the domains of the natural are increasingly technologically mediated, we have become increasingly dependent on the technologies, on access to the technologies, and on those experts whose knowledge and power create and control the technologies. Consequently, there is both greater epistemic and political dependence on experts, who rise to a position of dominance in defining and creating what is regarded as "natural," "normal," and "healthy" alongside the correlative definitions of the "unnatural," the "abnormal," and the "pathological." (1996, 223)

The reliance on experts and the power they wield in commercialized reproductive alternatives is key to understanding how whiteness is policed in cases of infertility. The combination of biomedical authority with normative whiteness can result in white heterosexual couples being considered as the most appropriate users of ARTs.

Social forces and racialized family ideology act in concert with technology and science during the course of diagnosis and treatment of infertility. Since biomedical practices themselves reflect cultural values, the use of biomedical technology partially reproduces cultural ideologies, power relations, and structural inequities (Lock and Kaufert 1998). In the case of ARTs, the value placed on white heteropatriarchal families is reflected in the development of technologies that enable infertile patients to reproduce biologically in ways that create biogenetic ties while seemingly ensuring racial purity. Technological health-care experts—who are often instrumental in deciding the direction of new reproductive technologies—are in a unique position to exercise disciplinary power. Because of their mastery of biomedicine, physicians in particular have culturally sanctioned authority that extends to reproduction (Jordan and Davis-Floyd 1993). In addition, since race is an organizing principle central to the construction and treatment of disease in Western biomedicine, practitioners perpetually reify race as a valid classificatory system when they assess each patient primarily in terms of age, race, and gender (Garcia 2003). What appears to be voluntary choice on the part of consumers of infertility services is often shaped by "diffuse ideological pressures and constraining material structures" (Morgan 1996, 224). For example, biomedical experts shape choices through

actions as varied as serving as the primary authoritative source of information for infertile individuals to making decisions about appropriate referrals and treatments and to brokering the use of donated gametes. I am not arguing for a type of cultural determinism in which the choices made by practitioners and their patients are determined solely by conscious racial mandates. ART practitioners are not consciously devoted to controlling women's bodies or upholding whiteness. They are genuinely committed to relieving the suffering of women unable to bear children, but they are often oblivious to the subtle ways in which they perpetuate racial classificatory systems. As Morgan pointed out, "Practices of coercion and domination often are effectively hidden behind practical rhetoric and supporting theories that claim to be benevolent, therapeutic and protective of individual choice" (228). For example, as a service to potential consumers, semen banks will provide catalogs detailing donor characteristics, presumably to facilitate matching of donor characteristics with that of the potential social father. Yet it is the bank's personnel who decide what information about the donor will be highlighted and ultimately who is an appropriate donor. Semen banks also control access through policies that require customers to be under a physician's care. These policies complement statutes covering artificial insemination, which require a physician to perform the insemination, thus identifying physicians as the official "gatekeepers of fertility" (Ikemoto 1995, 1034).

Consequently, the current biomedical approach to infertility, with its focus on costly high-tech treatment and reliance on experts, bolsters a system of class- and race-stratified reproduction in which some people are empowered to nurture and reproduce while others are disempowered (Colen 1995). As Susan Sherwin has commented, ART "helps to support the existing power structures, because it provides reproductive assistance to the affluent and accepts the view that it is more important for the privileged to produce children of their own genetic type" (1992, 134).

Donor Insemination and Subversion

Not all ARTs support the white heteropatriarchal family model equally. Donor insemination, for example, can be used to subvert the white heteronormative kinship model in a number of ways. With the use of donor sperm in cases of male infertility, the female partner can become pregnant and give birth to a child with half her genetic material while the male partner will have only a social and legal connection to the child. This configuration disrupts heteropatriarchal kinship arrangements: the family will have one biological parent and one social parent who cannot claim genetic paternity. In this way, donor insemination disrupts ideals of manhood, fatherhood, and genetic continuity (Becker 2000, 135). Donor insemination can also be subversive when used by queer or single women because it separates procreation from heterosexuality,

as well as correcting the social misconception that a woman cannot successfully raise a happy and socially adjusted child without a man in the house. If women use donor insemination as a way to reproduce without heterosexual intercourse, it undermines the assumed naturalness of heterosexual reproduction and patriarchal privilege.

Donor insemination can also present a threat to the essentialist notion of whiteness. Donor semen is categorized racially, and sperm banks rely on donor self-identification and physiognomy to assess the validity of a donor's claim to whiteness. However, the sperm arrives in the physician's office disembodied in a sterile vial, with no material evidence of whiteness. The "unknown" genes of the sperm donor represent a potential destabilizing threat to the illusory purity of race as evidenced by physical markers. Sperm banks are sensitive to consumer fears about being inseminated with "the wrong sperm." To ease any fear of racial mix-ups, one bank provides an essentialist visual signifier by color coding the vials of sperm to match the donor's race as part of their Quality Assurance Program (California Cryobank 2006). Specimen vials of Asian donors have yellow caps, African American donors have black and brown caps, and Caucasian donors have white caps. Red caps on specimen vials refer to "unique ancestry donors" such as East Indian, American Indian, and Latinos, or to donors who belong to two or more racial groups. Using red to mark donors whose race cannot be categorized as "pure" reinforces the notion that other donors' races are somehow pure.

Sperm banks simultaneously manage the subversion of patriarchy and racial purity through the careful cataloguing of donors' physical characteristics, which are then used as a basis for "matching" and choosing the appropriate donor. There is a concerted effort to match the physical characteristics of the donor with the male partner and potential social parent. The list of traits to be matched—always headed by race and corresponding to racialized markers—can be quite exhaustive: hair color, hair texture, eye color, eye shape, eyelash length, eyebrow arch, nose shape, ear shape, skin tone, height, weight, and blood type. This catalogue serves as a proxy for proof of a donor's racial pedigree.

The goal of matching is threefold: (1) to increase the probability that the child's physical characteristics will be similar enough to suggest that the social parent could have contributed his own genetic material; (2) to mimic the physical attributes of what white Americans perceive as a biological family; and (3) to maintain secrecy about the use of a donor by ensuring that the child could "pass" as a genetic child and not be mistaken as a product of the mother's sexual infidelity. While the first two goals can be interpreted as reflective of biologism, of looking to what is considered "natural" in the context of a biologically related family and using that as a model for what should be desired in all families, the third goal is indicative of the raced and gendered nature of the heteropatriarchal family model. Judith Lasker and Susan Borg contended that men's biogenetic

link to their children must be demonstrable in order for them to maintain their dominance in the family and the society (1994). Taken together with measures in place at sperm banks to prevent accidental race mixing, at the root of matching are concerns about maintaining the fictions of paternity and racial purity for white fathers (Ikemoto 1995, 1027).

Women of Color at the Sperm Bank

Donor insemination can be done in ways that subvert the white heteropatriarchal family model, but it can also be a site of struggle and contestation over the meanings of kinship, race, and biogenetic ties. Matching donor and family profiles manages potential disruptions to the racial order. But when those who veer from heteropatriarchal norms of whiteness use donor insemination, race and gender norms are sometimes challenged. For example, when the social father is white and the biological mother is not, the tactics developed to maintain the fictions of whiteness and paternity are more fragile and subject to challenge. Biomedical practitioners may become hypervigilant about donor choices to keep boundaries of whiteness from blurring.

My own theoretical reflection on the intersections of whiteness and reproduction is based on sets of interviews with Asian American, Latino, African American, and Native American heterosexual couples.[6] As a medical anthropologist, I am confronted with my interviewees' pain and suffering, so my work must straddle theory and practice. To make my work relevant to the lives and concerns of infertile men and women, I follow Morgan's insistence on working and reflecting "from the ground up" (1996, 212). I collect and examine the personal narratives of people of color using ARTs.[7] Understanding these narrated experiences informs and nuances my theoretical critique of race, reproduction, and ARTs, and moves toward engendering new visions and avenues of social change.

Race was always a subtext in Native American, African American, Asian American, and Latino narratives. References surfaced at varying levels, in different contexts and in response to interactions which primed that particular aspect of the self. One notable area in which race surfaced was when respondents described problematic interactions with biomedical practitioners who attempted to monitor their access to donor gametes and to make decisions for them.

Nori's Story

Both Nori and Edward have been married before. Edward has five children from his previous marriage and is indifferent to having more children. He has an irreversible vasectomy. Nori, however, has always wanted a large family. She

felt "lied to" by her ex-husband about wanting children. Over her three-year marriage with Edward, she has had six inseminations with donor sperm. She explains how frustrated she was in general with the process of choosing a donor, and the difficulties she had communicating with her doctor in particular:

> Interviewer: What cryobank did you use?
> Nori: I don't know where he [Dr. L] got it from. He didn't tell me where he got it from. He wouldn't let me select the sperm either. He selected it. So, I had a great deal of anxiety about what he was putting into me.
> Interviewer: You were not allowed any criteria?
> Nori: He wouldn't let me know. He looked at Edward and says—well, he didn't even look at Edward—"How tall is Edward? What nationality is he? What color are his eyes?" That's all he asked.
> Interviewer: So he was trying to match the sperm donor to Edward?
> Nori: I suppose so.
> Interviewer: As opposed to you?
> Nori: Yeah. I should have been able to select it. . . . I had a lot of anxiety about what I was going to get. Maybe that prevented it because I don't know if I one hundred percent wanted to get pregnant. There was so much anxiety involved. And he was not a very nice doctor either. He never answered my questions.

The fact that Nori's physician excludes her from the donor selection process for her child's father is not an uncommon experience. Almost 75 percent of physicians never allow recipients to select donor gametes (Hanson 2001). Dr. L presumes to know what Nori wants and what she would select and all but forbids her from choosing among a range of options. Nori acquiesces to the physician's selection though she admits to being so disturbed and anxious about what Dr. L is "putting into" her that she attributes her failure to conceive to her emotional anxiety. The equality between physician and patient is a fiction, as the patient is "no match for the institutional authority at the provider's disposal to advance his own interests" (Donchin 1996, 488). The physician's refusal even to consider Nori's wishes demonstrates how the bioethical principle of autonomy breaks down when the encounter is between a woman of color and a male physician. Nori's husband, a white male, is more privileged in his physical absence than Nori is as a present embodied individual. Through the physician's efforts to match those traits he deems important—height, ancestry, eye color—he attends to Edward's patriarchal interests in demonstrating his paternity though the birth of children that will resemble him. As a Japanese woman, Nori contributes half of her genes to the child, but the potential child

cannot claim whiteness, even with the use of semen from a donor designated white. However, there is a chance that the child will inherit and phenotypically express some of the matched traits, thus enabling the child to "pass" as progeny of Edward, the white social father. The physician cannot control the boundary of whiteness but he does act to maintain the heteropatriarchal aspects of the family model.

After a series of unsuccessful inseminations, Nori was referred to a physician who allows her patients to choose their donor semen. Nori likes this arrangement, as she wants to select donors based on the criterion she judged to be most important—intelligence. With increased agency, Nori does not have to make her choice based on whether a donor's profile matches her husband's phenotypic traits; but it does not follow that her new choice to foreground intelligence resists systems of hierarchy. It turns out that Nori believes that intelligence is associated with race and varies by ethnicity. She chooses donors who are white not to match the race of her husband as Dr. L was doing, but because she believes they are the "intelligent race." The basis of her choice—intelligence versus matching—differs from that of Dr. L, but it is still race conscious, with whiteness as the reference point. Her narrative reveals that she believes that race, and thus intelligence, is inherited. Nori's complex exercise of agency is consistent with the white heteropatriarchal model of family that insists race is inherited while simultaneously rejecting the model's precept that children must resemble their father.

Beatriz's Story

Beatriz and Ted tried to start a family their first year of marriage. Beatriz is Hispanic and Ted is Asian American, and they describe themselves as "family oriented." After failing to conceive, they sought medical advice. Their doctor was convinced that their fertility problems lay with Beatriz, and never asked Ted to come in for testing. Frustrated with the amount of time spent without an accurate diagnosis and the doctor's lack of enthusiasm, Beatriz lost "total confidence" in that physician and went elsewhere. Their new doctor discovered that Ted's sperm had low motility, so Beatriz underwent two inseminations with donor sperm, but one was a bad specimen and the other was a bad insemination. She found yet another doctor and this time was pleased with the amount of control she and Ted had over the donor selection process.

> Beatriz: It's been really convenient. . . . I have to make the arrangements for the sperm myself. I have to call a bank in Los Angeles and they send me the list and then I make the selection and arranged for the shipping. . . . We go with the one in Los Angeles because they have the most extensive list . . . [for]

> matching Ted's characteristics as far as height, weight, hair color, and brown eyes. Medium skin. With the list L.A. has, we were able to choose from about four different donors and that's more than anyplace else. Anyplace else we didn't get anything.
> Ted: Then if you really want it, you can get some history background on the person.
> Beatriz: Yeah, and I really like getting that information because we really want our child to . . . I mean, we don't expect a child to look exactly like us. There's a chance he could look just like the donor. But as long as he has brown eyes and brown [hair] and medium skin and just blends, then we'll be happy. Not that we're going go to try and pass him off as this biological child.

Like Nori, Beatriz was unsatisfied with her initial forays into infertility medicine. In an example of what can be characterized as biomedical chauvinism, Beatriz's doctor insisted that her physiology was the reason why she could not conceive, and so he did not follow the standard American Society for Reproductive Medicine diagnostic protocol for heterosexual couples, which is to test both the man and the woman concurrently. Moreover, he was reluctant to perform the test to detect sperm antibodies Beatriz explicitly requested. Again, as in Nori's case, autonomy and agency were undercut when the encounter was between a woman of color and a white male physician.

With her third physician and current medical provider, Beatriz now claims that she and Ted are "real happy," due in large part to more comprehensive insurance coverage and the freedom from physician oversight they now have when choosing donor sperm. Beatriz's physician does not advise her on the "appropriate" phenotypic characteristics of a donor and leaves the selection process entirely up to her and Ted.

When discussing how she chooses a donor without physician input, Beatriz mentions trying to match Ted's characteristics. This echoes Nori's first physician's focus on producing a child with convincing paternity. However, what is most striking is that Beatriz does not refer explicitly to the race of the donor. They do not search for an Asian or Hispanic donor but for "brown eyes and brown [hair] and medium skin," which could match either Beatriz or Ted. While they adhere to the aspect of the kinship model that focuses on appearance, their aim is not to ensure racial purity. Instead, Beatriz narrates her choices in terms of "blending" and not in terms of racial matching. Furthermore, she explicitly rejects the notion of passing off a child born using donor sperm as Ted's biological offspring. Here, she is undermining the white heteropatriarchal model, which insists that the demonstrability of paternity be maintained and the purity of race be manifest.

Raeshell's Story

Raeshell and Tom were married four years before they consciously started trying to have a child. Raeshell had been off the Pill for three years and, in their words, they hadn't had any "accidents" so they decided to seek a medical opinion. After a semen analysis, they were told that 85 percent of Tom's sperm were abnormal, possibly due to his exposure to chemical agents at his job. After thinking it over, Tom and Raeshell decided to consider donor insemination. Raeshell was angered by her interaction with the first physician they consulted.

> Raeshell: We talked briefly and he asked me whether or not I had any questions. Well, I just said, "Well, how do you try to match the physical characteristics of the husband?" And he says, "Well, you know unless your husband has any real distinguishing features, usually it's not difficult to do that." And I said, "Well, I think my husband's most distinguishing feature is the fact that he's black." . . . And he goes, "Oh, I don't have any black donors in the program." . . . And immediately in my mind, I kind of moved past it. I said, "Okay, well, I'll take anything in, you know, in the color range." I said, "If you have, you know Hispanic, Puerto Rican, you have somebody, I mean, a tangent. I mean, those are all people with African descent over history and time; hey, I'm not going to be too flipped out or too choosy about it. I'm open. It's only sperm. And the baby is gonna be half black or something because it's going to be my baby, right? So, I didn't trip off of it. And he says to me, "Oh, no, I do not think that would be appropriate at all."

Immediately noticeable in Raeshell's narrative is the clash of ideas about race and racial purity. To Raeshell, race is fluid. For the doctor, race is fixed. She constructs her own identity as a black woman realizing that there is no racial purity, that there are peoples with African descent who are not classified as black by societal categories. She goes on to say: "And the baby is gonna be half black or something because it's going to be my baby, right?" Raeshell is black and so any child she has, regardless of appearance or genetic makeup or racial identity of the sperm donor, will be considered to be black and will be raised as black. While she acknowledges the importance of the biogenetic tie, she also does not credit it with the power to determine race. In this, Raeshell's understanding of race is at odds with the white heteropatriarchal model of kinship, yet congruent with beliefs found in the African American community (Roberts 1997, 263).

Raeshell's fluid view of race and family is, no doubt, partially a consequence of historical patterns in which black biological family units were repeatedly

disrupted by white violence and government legislation around reproductive issues. Other women I interviewed, who held fluid views of race and family, also identified as members of groups with histories of oppression that disrupted families. Native American women explicitly mentioned the U.S. government's long-standing policy of taking children from their tribal families and sending them to off-reservation boarding schools where they were abused and forcibly assimilated into white culture. Chinese American women spoke about the presence of "paper sons" in their families.[8] To these stories we can add the histories of broken families under slavery, forced relocation of Native Americans, and the emergence of informal adoption as a survival strategy for African Americans and Latinos.[9]

I didn't have the opportunity to interview Dr. P and I don't presume to know his views on race. However, I imagine that his remark about the inappropriateness of using nonblack semen for Raeshell's insemination comes from a number of places. First, it's rare to find a clinician who does not adhere to rigid systems of classification based on historical notions of race. In addition, his primary clinical experience might have been treating white patients whose racial boundaries are not likely to be fluid. The unease Dr. P expresses may arise from Raeshell's proposed transgression of the racial boundary through choosing a nonblack donor. Her selection signifies the mutability of race and the ease with which whiteness can be endangered.

Raeshell consulted another fertility specialist, Dr. S, who counseled her, "Don't try to have too much control over this," which contributed to her feeling that she was helpless in this process.

> Raeshell: I would take a fair-skinned donor over a dark-skinned black male, but what I am getting from the medical side is that they don't feel that that's appropriate. As long as there's any black male available, that person as a donor is preferential to any other donor out there, and I don't feel that way.

Raeshell wants the donor to look as much as possible as her husband Tom, who is light-skinned. She is frustrated with the physician's view, which ignores the fact that a wide variation in skin tones exists in black communities. Her bitter appraisal of their attitude that "any black male available" will be an appropriate donor regardless of physical attributes calls up the prejudiced phrases "can't tell them apart" or "they all look alike." A white person who can't tell members of another racialized group apart sees them only as blacks, or Latinos, and not as individuals. This is a consequence of whiteness defining race. As Chambers has noted: "Whiteness itself is atomized into invisibility through the individualization of white subjects," while nonwhites are perceived first and foremost as a function of the group to which they belong (1997, 191).

Raeshell interprets the interchangeability of her husband with any black donor as reflective of a typical white depersonalizing stance. This angers her and contributes to her feeling of not being in control. It suggests that a different, unspoken standard of donor matching holds for African Americans and other nonwhites, where race outweighs all other physical attributes. Raeshell's physicians are not concerned with matching her husband's physical characteristics; they are only interested in her using black sperm. These concerns did not arise in the previous narrative when Dr. L's took considerable efforts to match Edward's physical characteristics.

Raeshell's response to the policing of donor gametes she has encountered is complex; she simultaneously rejects notions of the inheritability of race while insisting on adhering to the aspects of the heteropatriarchal model of family which requires that children must look like their father while also acceding to the practice of privileging light skin still common in many African American communities.

Possibilities for Resistance

The experiences of Nori, Beatriz, and Raeshell illustrate how women's agency during the process of donor matching is shaped by racialized preconceptions about kinship. Despite these obstacles, when women of color confront the biomedical policing of their choices, a space opens up where they can potentially undermine or reinforce whiteness and patriarchy, reinscribe ideas of relatedness based on appearance, or perhaps do both in the complex practice of agency. Exercising agency does not always have to be resistant: sometime their choices reinscribe white kinship models and other times they don't. Regardless, these women's experiences raise the possibility of transforming the dominant white heteropatriarchal model of American kinship and family, starting with the idea that genetically inherited physical markers determine race. Our willingness and ability to resist white genetic imperatives and instead articulate a model of family in which the social aspects of parenting and kinship are primary would be one way to undermine the idea that heritable biogenetic ties are essential to defining family. Biomedical practitioners must become aware of they ways in which their outdated concepts of race inform their recommendations about donors. They must come to understand how race shapes their understandings of family and the role they play in maintaining the viability and power of whiteness.

Lisa Ikemoto argued that the use of technology for reproduction intervenes in our ways of thinking about normal boundaries of use beyond norms of appropriate family structure, so that "technology is thought of as both constitutive of boundaries and as a means of exploring beyond existing boundaries" (1995,

1013). She was asking us not to forget the liberatory potential of ARTs, for "if we can invent humans, we can certainly invent family." It is possible to decouple ideas of family and biology, to reconsider genetic essentialism, and to dissolve the naturalized boundaries of race. As Laura Shanner predicted, in considering the experience of infertility and ARTs from the perspective of a woman of color, we can "begin to see a different set of practical problems, different sorts of solutions for those problems, and new ethical issues to be addressed" (1996, 116). The stories of women like Nori, Beatriz, and Raeshell reveal the nuances of these experiences, moving us beyond reinscribing heteropatriarchal family models, and perhaps helping us envision new paths to social change.

Notes

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1. For accounts of this event, see ABC 2004; Christoffersen 2004; *New York Post*, July 10, 2004; *National Post*, July 16, 2004; WHDH 2004; and WTNH 2004.

2. Intrauterine insemination (IUI) places a concentrated specimen of processed sperm into the uterus. To increase chances of fertilization, the woman may be required to take fertility drugs to induce the release of multiple eggs per ovulatory cycle. In vitro fertilization (IVF) is a procedure in which eggs and sperm are mixed in a petri dish under optimal conditions for fertilization. Intracytoplasmic sperm injection (ICSI), a variation on IVF, is a procedure where a single sperm is injected directly into the egg. Fertilized eggs are then transferred to the uterus. These procedures require the woman to hyperovulate and then undergo the "harvesting" of eggs through laparoscopy.

3. See, especially, Callahan 1995; and Murphy 1999. For an overview of feminist critiques of ARTs, see Donchin 1996; and Thompson 2002. Racial critiques include Nsiah-Jefferson and Hall 1989; Hartouni 1994; Ragoné 1994; Roberts 1997; and Rapp 1999.

4. More flexible notions of kinship not linked to biology have been reported among African Americans (Stack 1974); Latinos (Kemper 1982); gays and lesbians (Weston 1991); and Asian Americans (Dill 1994).

5. According to Schmidt and Moore (1999), technosemen is the result of technologically based semen analysis and manipulation, which includes sperm counts, morphology and motility testing, functional testing and sperm washing, genetic and disease testing, and cryopreservation.

6. Twenty-two men and twenty-three women were interviewed between 1992 and1996. I did not conduct all of the interviews, but had unlimited access to additional audiotapes and transcripts. The narratives of the seventeen couples using artificial insemination are most central to this essay.

7. My method of examination is a combination of discourse analysis, narrative analysis, and antiracist feminist analysis. I analyze narratives in terms of their internal coherence and contradiction, their relationships to one another, and in the context of a broader social history. I base my interpretative framework on common themes that emerged through close attention to repeated phrases, language and expressions, as well as emotions expressed at significant junctures in respondents' narratives.

8. See Adams 1995 for information on the boarding school experiences of Native Americans; Hollinger 1989 for fosterage and adoption of Native American children by white families; and Hing 1993 for the effects of immigration policy on Chinese Americans.

9. See Patterson 1998; Philp 1999; Dill 1994; and Hardesty and Black 1999.

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